Appendix A: Provider Monitoring and Oversight Activities

Monitoring Activity	Conducted by	Applies to	Purpose	Frequency	Includes
Endorsement	LME	Medicaid-funded MH/DD/SA services	-To ensure individuals receive services and supports from organizations that comply with State and Federal laws	-New provider -Addition of new site or service -Business verification completed every 3 years following endorsement	Business Entity Verification: -Assurance that the provider organization is in compliance with 10A NCAC 26B, 27C, 27D, 27E, and 27G .0299 and is currently registered with the local municipality and/or the Secretary of State and that there is no dissolution, revocation, or revenue suspension findings currently attached to the provider organization On-Site Endorsement Review A service-specific checklist which includes the following elements: -Provider organization requirements -Staffing requirements -Service type/setting requirements -Clinical requirements -Documentation requirements Within 60 days of the provider organization accepting consumers and delivering services, (post endorsement and enrollment), another on-site review is conducted to review checksheet items related to components of the consumer record.

Appendix A: Provider Monitoring and Oversight Activities

Monitoring Activity	Conducted by	Applies to	Purpose	Frequency	Includes
Frequency and Extent of Monitoring (FEM)	LME	Category A and B Providers of state funded and Medicaid funded services (includes fee-for-service and CAP-MR/DD services): Category A - facilities licensed pursuant to G.S. 122C, Article 2, except for hospitals; these include 24-hour residential facilities, day treatment and outpatient services Category B - G.S. 122C, Article 2, community based providers not requiring State licensure	-To assist the LME in scheduling and in determining the frequency, scope, and intensity of local monitoring of service providers in their catchment area	-Following the LME's endorsement review or upon licensure by DHSR or contract with the LME and completed every 3 years thereafter -Updated as needed: ·Based on receipt of new information ·When significant changes occur that may affect the frequency of monitoring ·Upon request of the provider	Desk Review of: -Provider's Performance ·Provider's Longevity ·Staff Competencies and Experience ·Local Collaboration Activities ·Data Submission ·Quality Management ·Addition of a New Service (if applicable) -Oversight Agency Info ·Licensing Agency (if applicable) ·DSS ·DMH/DD/SAS ·DMA (if applicable) ·Accrediting Organization (if applicable) ·LME -Incident Reporting ·Reporting of Incidents ·Response to Incidents ·Patterns of Incidents -Complaints ·Policies and Procedures ·Responsiveness to Complaints ·Patterns of Complaints

Appendix A: Provider Monitoring and Oversight Activities

Monitoring Activity	Conducted by	Applies to	Purpose	Frequency	Includes
Routine Local Provider Monitoring (includes the PMT)	-LME	Category A and B Providers of state-funded and Medicaid-funded services (includes fee-for-service and CAP-MR/DD services) delivered across the provider agency within the LME's catchment area Category A - facilities licensed pursuant to G.S. 122C, Article 2, except for hospitals; these include 24-hour residential facilities, day treatment and outpatient services Category B - G.S. 122C, Article 2, community based providers not requiring State licensure	-To ensure compliance of a provider agency in key areas of performance and to identify any areas requiring more in-depth or targeted monitoring	As indicated by the FEM	Through a combination of record/documentation review and consumer and staff interview, the PMT is used to assess the following domains: -Quality Management Program -Protection from Harm—Provider Response to Incidents and Complaints -Staff Competencies and Experience -Person-Centered Planning -Person-Centered Services & Supports -Individual Rights
Focused/ Targeted Monitoring	LME	Any provider or MH/DD/SA services (directly enrolled or under contract with the LME)	-To address issues or concerns identified during routine monitoring or as a result of information obtained from other sources -To determine the extent of noncompliance	As needed	-In-depth monitoring of compliance to specific rule and statutory requirements

Appendix A: Provider Monitoring and Oversight Activities

Monitoring Activity	Conducted by	Applies to	Purpose	Frequency	Includes
Complaint/ Incident Reviews	-DMH Accountability Team Regulatory Unit -DMH Customer Service & Community Rights Team -DHSR -LME	Any provider or MH/DD/SA services (directly enrolled or under contract with the LME or licensed under G.S. 122-C)	-To safeguard the health and safety of the individuals served and to identify areas of correction and improvement -To ensure protection from abuse, neglect, or exploitation	As needed	Targeted review to determine the validity of allegations (which can include billing and documentation) as well as critical incidents involving consumers
Subrecipient Monitoring	-DHHS -LME	-Entities that receive federal or state pass-through funding in the form of financial assistance grants to carry out the goals of a specific MH/DD/SA program (e.g. MHBG, SAPTBG, TASC, Teen Smoking Cessation) -When LMEs subcontract state or federal programs to other entities in the form of a financial assistance grant, those entities become subrecipients of the LME and the LME is responsible for monitoring those grantees	-To ensure that state or federal awards are used for authorized purposes in compliance with laws, regulations, and the provision of contracts or grant agreements and that the performance goals are achieved	Determined by risk assessment and provisions of the contract	Assessment of compliance with OMB Circular A-133 requirements pertaining to: -Allowable activities -Allowable costs -Eligibility -Reporting -Other special tests and provisions of the grant program

Appendix A: Provider Monitoring and Oversight Activities

Monitoring Activity	Conducted by	Applies to	Purpose	Frequency	Includes
Post-Payment Clinical Reviews	-DMA Program Integrity Unit -LME	Medicaid-funded MH/DD/SA services	-To ensure that services delivered are clinically appropriate and in accordance with federal and state statutes as well as with relevant DHHS policies, manuals, and communications	As needed	Review of documentation to verify: -Medical necessity of the service -That the service was provided consistent with the service definition -That the documentation supports reimbursement of service delivery -That staff qualifications were met for the provision of services
Division of Health Service Regulation (DHSR) Surveys	DHSR	MH/DD/SAS Facilities licensed by DHSR	-To ensure compliance with core rules (10A NCAC 27D, 10A NCAC 27G, and G.S. 131E-256) impacting the health, safety and welfare of clients	At least annually	Review of: -Physical Plant -Client Protection -Staff Qualifications & Competency -Client Treatment -Client Services & Medications Noncompliance in these areas may trigger a more in-depth survey of the specific rule and related areas and a Plan of Correction
Medicaid Audits	DMA and DMH/DD/SAS (LMEs have assisted with audits)	Medicaid-funded MH/DD/SA services	-To ensure that services are provided in accordance with state and federal regulations -To ensure that documentation and billing practices demonstrate accuracy and integrity -To ensure that medical necessity has been determined -To monitor the quality of the documentation of services provided	Audits done semi-annually or as needed on a sample of services/providers	Review of: -Authorizations/PCP or Plan of Care -Service Documentation -Staff Qualifications/Supervision/ Record Checks

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Monitoring Activity	Conducted by	Applies to	Purpose	Frequency	Includes
Accreditation	Accrediting entity	Providers of those CIS and CAP-MR/DD services that require national accreditation	-To ensure providers meet nationally accepted standards regarding quality, organizational structure and consumer care	Frequency of on-site visits and follow up vary by accrediting entity	A review of the provider's basic infrastructure related to certain key components, including: -Ethical governance -Financial accountability -Human resources -Quality management -Risk management -Service delivery administration Review of the following through documentation reviews/interviews to determine compliance with accreditation standards: -Service records -Personnel records -Incident report -Business practices -Client/Legally responsible person satisfaction -Community involvement
Plans of Correction* ***Note that POCs are a result of other monitoring activities**	-LME -DMH/DD/SAS	Any provider of MH/DD/SA services (directly enrolled or under contract with the LME)	-To ensure successful implementation of appropriate corrective actions related to out-of-compliance findings from reviews, audits, monitoring, or investigations	As needed	Review and approval of POCs as well as monitoring implementation

Appendix A: Provider Monitoring and Oversight Activities

Monitoring Activity	Conducted by	Applies to	Purpose	Frequency	Includes
Abuse/Neglect/ Exploitation Investigations	DSS	Caretakers -For disabled adults, this would apply to a provider with "comprehensive responsibility for the adult's day-to-day well-being" -For children/youth, this would apply to a provider with "responsibility for the health and welfare of a juvenile in a residential setting"	-To ensure protection from abuse, neglect, or exploitation	As needed	-Review to determine the validity of allegations -Possible reporting/referral to the District Attorney or other regulatory agencies (e.g. DHSR, DMH/ DD/SAS)